DOCUMENT RESUME

ED 328 009 EC 233 222

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TITLE Quality Services Management: A Consumer-Oriented Model for Systems Audit and Strategic Intervention.
PUB DATE May 90
NOTE 16p.; Paper presented at the Annual Meeting of the American Association on Mental Retardation (Atlanta, GA, May 27-31, 1990).
PUB TYPE Reports - Descriptive (141) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Accountability; *Delivery Systems; *Disabilities; *Evaluation Methods; Formative Evaluation; Human Services; *Program Evaluation; *Quality Control; *Systems Approach
IDENTIFIERS *Quality Service Management

ABSTRACT

The paper describes Quality Service Management (QSM) as applied to the provision of services to disabled and other special needs persons. QSM is defined as a systems approach to consumer relations based on the belief that quality care may be achieved only within the context of overall services management. Differences among "quality accountability" concepts such as quality control, quality circles, quality assurance, and quality services management are explained. QSM is an internal monitoring system which targets the specific criteria of timeliness, accuracy, outcome/results, conformance to requirements or procedures, and recognized standards of care or benchmarks of quality. The system records performance on selected indicators of quality in administrative, clinical, fiscal, physical, and programmatic audit areas. Six steps for QSM implementation are outlined: (1) develop a mission statement, philosophy, and goals and appoint a coordinator; (2) define service areas for audit; (3) operationalize the process; (4) develop reporting protocol on which indicators will be recorded; (5) establish internal monitoring schedule; and (6) design and implement a training program. A suggested classification system for performance indicators is attached. Includes 18 references. (DB)

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Quality Services Management: A Consumer-Oriented Model for Systems Audit and Strategic Intervention.

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General Description: Quality Services Management is a systems approach to consumer relations based on the belief that quality care may be achieved only within the context of overall services management. The system views the client, client's family, and friends as consumers of services. Combining client care management and facility systems management, quality services management ensures the coordination and delivery of quality services from all staff and at all levels of the organization. This system addresses the important role of all service staff as monitors of quality care, sound administrative and fiscal practices, and service provision in effective community or residential settings. Consumer relations/quality services management audit of administrative, clinical, fiscal, physical, and programmatic systems ensures a comprehensive analysis of selected indicators and performance measures, evaluated according to predetermined criteria. Evaluative criteria, developed by all staff, provide the basis for initiating corrective action plans and ensures timely review of systems audit for continued quality services both in community and residential settings.

Objectives: At the conclusion of the program, the participant should be able to demonstrate:

1. An understanding of and differences inherent in concepts of quality control, quality circles, quality assurance, and quality services management,

2. An awareness of macroenvironmental and microenvironmental issues and concerns facing management in developing and implementing internal monitoring systems,

3. Familiarity with prerequisites to successful system development and implementation,

4. Familiarity with the basis premise and system design, function, and implementation of quality services management, and,

5. An awareness of administrative issues impacting services providers, clients, parents, advocates, and people striving for programmatic accountability and effectiveness.

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TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

REVIEW OF PROGRAM OBJECTIVES AND AGENDA AND BASIC ASSUMPTIONS ABOUT THE EVALUATION OF QUALITY

For the next 45 minutes, we will discuss the concepts of quality and quality services management. QSM is a system of internal monitoring of selected indicators of program performance and outcomes. QSM encompasses regular, dedicated audits of administrative, clinical, fiscal, physical, and programmatic indices. As we discuss QSM, we will accomplish five (5) objectives.

We will discuss some basic assumptions about quality, its origins as an "accountability" measure and why its operational definition and measurement is important. We will explore current issues affecting system design and implementation and requirements for successful interval monitoring. Lastly, we will review quality services management, its basic premise, system design and function, and certain administrative issues inherent in responsible, proactive service delivery and programmatic activism. Programmatic activism is defined as proactive service delivery which empowers staff with the responsibility, either bestowed or implied, to generate positive outcomes on behalf of clients, families, staff, and the system within which the affected staff are members, to facilitate change, and to ensure optimum availability of needed resources. (Baker, 1990).

Don't expect to learn that one system or interpretation of quality is better, stronger, more reliable, more appropriate for differing service settings. There are many systems used in allied fields as well as our own. Quality assurance, as most often discussed, has several characteristics, such as the monitoring source, formality of the assessment, nature of data collected, nature of the feedback, and aspect of the program under evaluation. Approaches vary depending on what is being assessed and on who is carrying out monitoring activities. No system exists which meets the needs of all service providers and consumers. What you should remember was stated by Philip Crosby (1979): "Quality is free. It's not a gift, but it's free. What costs money are the unquality things--all the actions that involve not doing jobs right the first time."

Before we explore QSM in detail, let's review some basic tenets. What do we know about "quality"? Why is its measurement, its operational definition important to us? What changes have and are occurring in human services that reinforce our determination to give substance to this elusive concept? and what can we learn from other managerial ideologies to improve our odds in satisfying measurable criteria?

To answer such questions, we must recognize that quality has a great many definitions influenced by individual circumstances and perceptions. In our field, multiple constituencies have become recognized and accepted when discussing service options. Quality is an important aspect of these constituencies' assessment and valuation of services.

Service providers, clients, parents, legislators, advocates, and surveyors may have differing perceptions, relatively speaking, of quality, and the means to put definitions of quality into practice in living, working, and learning environments. While each definition has value, for the purpose of our discussion, we'll concentrate on issues facing administrators and service providers in the role of quality monitors.

ORIGINS OF "QUALITY ACCOUNTABILITY" CONCEPTS

To understand how quality and its measurement has emerged into the human services arena, we need to research briefly its introduction and function in other allied administrative areas, particularly, business, industry, and healthcare services.

Business and Industry

In the decades that followed World War II, Japan struggled to overcome the perception in world markets that its products and technologies were synonymous with "cheap junk". By means of specific managerial innovations and strategies, the Japanese refocused their industrial philosophies with heavy emphasis on quality and its application in business, production, and service outcomes. Quality circles emerged throughout the country's corporate structure. Quality circles utilize industrial workers from the same unit who volunteer to develop solutions for specific unit problems. Quality control is another industrial-based term which has its origins in business and industry. Quality control is a system of regular, planned inspections designed to provide good and low cost products, dividing the benefits among consumers, employers, and stockholders.

To go back to its earliest origins, quality assurance had its inception during the missile years in the defense industry. Paralleling that development, related industry picked up on a good thing. For a time, America's corporate structure has seemed to lag behind its foreign counterparts. Some would argue that quality problems remain the single greatest impediment to our future economic survival as a world power. Nevertheless, American companies struck a revival chord with workers and consumers alike in seeking quality in production. You've all heard commercial expressions such as "Quality is Job 1", "Quality goes in before the name goes on", and "Quality--uncompromising and unchanging". According to Bradley and Bersani, these expressions are the result of a desire for standards yielding a product that performs both reliably and predictably, a desire that transcends work settings.

Simply defined, quality may mean a characteristic or aspect of some phenomenon, an attribute. Its functional definition is performance against a standard. Quality assurance lends a measurable value to certain indicators of service provision. An indicator is an objective, measurable dimension that provides information on the quality or appropriateness of an important aspect of service, care, problems, or patterns. Social

relationships, access to community resources, privacy, recreational opportunities, or informed consent are examples of indicators subject to measurable valuation.

Healthcare Services

During the period 1950-1975, the healthcare industry refined its early attempts to address quality in patient care via Joint Commission on Accreditation of Hospitals Organization (JCAHO) standards. JCAHO reintroduced a clinical orientation in its 1984 edition and with that publication a revised quality assurance standards. That standard places responsibility with departmental chairpersons for ensuring implementation of a systematic process for monitoring and evaluating quality and appropriateness of care within each department. (Dronsfield, 1989). The litigious nature of providing healthcare reinforced another allied component of quality assurance. This component, risk management, is designed to minimize risk of financial loss to healthcare providers and manage risks to patient safety. Through adequate levels of liability insurance coverage and loss prevention programs, healthcare institutions reduce their position of jeopardy. (Purcell, 1988).

Human services professionals have benefitted from the development of quality assurance in other service and corporate industries. During the late 1960s and the decade that followed, the Health Care Financing Administration promulgated ICF and ICF/MR standards. These standards were brought about to correct systemic abuse observed in facilities caring for citizens with disabilities. At that point, absence of external or internal monitoring of client rights was blamed for these conditions. Regulations in place since 1974 and revised in 1988 now govern operations in an estimated 3,600 program sites. These sites serve from four to 1,500 persons. In meeting such regulations, administrators face an additional challenge in ensuring clients an optimum level of services within parameters which offer citizens a participatory role in evolving their living, working, and learning environments.

Current Issues Affecting System Design and Implementation

In the more pragmatic sense, administrators must confront, analyze, and strategize external and internal factors impacting on the service setting and its participants if quality assurance measures, (QSM) are to be effective. Disregarding macro and microenvironmental issues generally sabotages quality efforts and at the very least, wastes an inordinate amount of time.

Dufresne (1989) speaks to certain macroenvironmental issues with which service providers contend. No one who deals even superficially with such issues would diminish the credibility of his statements. Within a highly regulated industry of human services, such regulations have increased

tenfold. For example, comprehensive regional centers may receive external oversight from an estimated 12-15 separate state and federal monitors assessing administrative, fiscal, clinical, and programmatic compliance. Administrators find themselves juggling two balls with one in the air, with an ever increasing sense of frustration. Effective internal monitoring systems must not compound negatively the impact of societal, governmental, economic, and technological forces influencing the organizational operation. Unless internal systems streamline the monitoring process, the system stands in danger of becoming entangled further in this mass of regulations, overloading already stressed administrative responsibilities.

Microenvironmental issues, or internal factors, include positive and negative influences, as well. In designing your internal monitoring system, the most immediate factors to address are: 1) organizational culture, its values, and depth, 2) its managerial influences, style, and attitudes, 3) short and long term goals, and 4) consumer status.

Requirements for Successful Internal Monitoring

Both macro and micro factors are present and influence organizations. Internal factors tend to offer administrators a greater number of opportunities to affect the infrastructure through guidance and leadership. Certain micro factors are directly related to requirements for successful internal monitoring. Cashen (1989) cited five (5) characteristics present in exemplary quality monitoring programs. These characteristics are: 1) a clear mission statement, 2) active, participatory staff, 3) high degree of staff-staff and staff-client interaction, 4) organizational respect for innovation, flexibility, and encouragement for improvisation, and 5) executive leadership committed to responsible interaction for quality services.

Strategists across business, industry, healthcare, and allied fields are emphatic on their consensus of these points, and particularly strong on two (2) aspects of system development...the absolute necessity of a clear mission statement and executive leadership. If you don't know where you're going, any road will take you there. Without a clear mission statement, organizations may wander without firm direction. Mission statements are markers, sign posts, offering guidance and direction to an end destination. A mission statement isn't lofty rhetoric or professional jargon. In its most functional form, a mission statement becomes the organization's common purpose for all employees. It is stated in terms which are clear, understandable, useful. It tells all employees what the organization does, values, its value of quality, and its intent to achieve quality in daily operations.

The other critical variable is the organization's leadership. The success of any internal monitoring system, whether called quality assurance, quality services management, or total quality management is directly related to the organization's leadership, its demonstrated commitment to quality and the system, and its continued unflagging, unwavering,

relentless participation in its achievement, improvement, and communication.

Memos aren't sufficient. Memos say "support" not "participation". The quality anticipated deserves and requires active, time in, hands on involvement of management from the highest levels of the organization to perceive work settings as workers and consumers perceive these environments. Administrators cannot delegate their role in this regard, nor should they attempt to if the system is to success in its long term benefits to all participants.

It is not within the scope of this discussion to detail extensive organizational development issues. Suffice to say, the tacit values, formal and informal structures, problem-solving modes, climate for change, and willingness to invest fiscal and human resources in a long-term program within any organization bears heavily on its monitoring system and client satisfaction. Your syllabus contains two (2) separate references, by Albrecht and Wray, which offer excellent discussions on the interplay of these critical factors. Your system, and its long term success will be affected by such factors.

Quality Services Management

As an internal monitoring system, quality services management exceeds quality assurance systems vis-a-vis its conceptual framework. Developed for use in healthcare settings, its use in human services presents exciting implications. QSM is a dynamic process which encourages proactive service delivery rather than reactive assessment/reassessment of systemic problems and solutions.

QSM is characterized by an organizational mindset which views its key participants in a manner different from quality assurance programs. Basically, this mindset employs six (6) strategies for communicating the QSM philosophy to service providers, consumers, advocates and other people interested in quality services: 1) Every employee action impacts client satisfaction. Efforts to improve client satisfaction are doomed to fail it they extend only to those who come in direct contact with clients. Quality service is the responsibility of every employee. Everyone--from administrator to maintenance worker--affects the quality of client services. 2) Consumer satisfaction and employee satisfaction are the same. An employee cannot be expected to deliver quality service to the consumer unless the employee receives quality service from the employer. 3) Quality begins at the top. It the responsibility of managers to create a climate for personal and professional growth for every employee. The quality of an employee's performance is directly linked to the conditions in which he or she must perform. 4) Accountability is essential to client satisfaction. Quality service is ensured only when accountability measures are in place, clearly delineated, understood, and accepted by every employee. Employees perform best when expectations are clear, concise, and concrete. 5) Client satisfaction is more readily achieved when employees

and management work as a team. Client dissatisfaction indicates a problem with the total facility system, not with an isolated component of the system. When the facility works as a team, everyone shares responsibility and solutions are explored in all avenues of service delivery. 6) Clients are the experts at defining quality service. Clients know what they want, what makes them feel good, and whether or not they are happy with the services they receive. Their active participation in evaluating the quality of services is an essential component of the system's effectiveness and success.

Simply stated, quality services are a result of clear expectations, enlightened systematic management, individual employee pride and performance as a team member. To be an effective tool for both consumer and provider, quality services must be monitored and evaluated on a regular, consistent basis. When translated into a human services setting, QSM targets certain criteria which relate to overall quality of services provided in living, working, and learning environments. These criteria may be applied to other quality control or quality assurance measurement systems with which you may be familiar: 1) timeliness, 2) accuracy, 3) outcome/results, 4) conformance to requirements or procedures, and, 5) recognized standards of care or benchmarks of quality.

QSM focuses attention on every employee as important to consumer satisfaction. Every person is responsible for the quality of services provided by the agency. Departmental lines may blur, not to diminish lines of operational communication, but to encourage everyone to participate in total system action to achieve facility-wide or program-wide results. "Ownership", "departmental turf" or "professional sensitivities" are counterproductive when everyone is important to the successful provision of services of measurable, valued quality. As conceptualized, quality services management may be implemented in almost any setting...without undue concern about size, location, or staff experiences. Regardless of the service setting, early on, as many staff as possible must help in development of the mission, philosophy, and goals of the QSM program. Every department or level of staffing may have valuable observations about how quality is achieved, what aspects of service are important for measurement, how often these service indicators should be measured, who should conduct the measurement, how the reporting mechanisms should be structured, etc. Staff participation, beginning with the program administration, is essential at this stage. Extensive staff participation sets the stage for later program implementation and communicates to everyone that participation in the program is a "given" part of assigned daily responsibilities. Full staff participation communicates the concept that everyone's comments, opinions, suggestions, or recommendations are valued and worthwhile for serious consideration. Clients and their families have useful information to contribute and their participation should be solicited. They have differing perceptions of quality..what makes services worthwhile, helpful, what aspects of staff-client interaction contribute to their dignity and self-direction, and what aspects of services need improvement to promote greater independence and

progress.

The importance of this stage of system development is twofold: 1) Full staff and client participation communicates to the system's users that the expectations for quality services and everyone's daily actions to promote quality are valued and essential, and 2) opportunities for staff and client input yield information about these participants' values..what is important to the people who will be working with and depending on this system. Research in organizational structures tells us that the value system of the organization is composed of the individual and collective values of its members and subgroups. Hence, the success of the organization's mission and daily operations is directly related to the ability of the organization to articulate the values of its members into an expressed whole..a shared understanding of and relating to the concepts valued by the organization. In absence of this shared value system and the capabilities of the organization to sustain shared values, efforts to affect quality or its measurement will be diminished to a large degree.

To a large extent, almost any system is and becomes value-driven and is in an evolutionary state, changing indicators to reflect changing service priorities. Quality services management is a dynamic rather than static collection of goal statements. The system, as envisioned and implemented in daily practice, causes its participants to look more carefully at issues beyond essential regulatory compliance. When QSM establishes "standards" or "requirements", participant users of this system are educated to develop an accompanying mindset that their "standards" are higher than those mandated by external monitors. These expectations are not necessarily written down nor are they measurable in all cases. The result is observable in clients' progress, ability to benefit from interpersonal contacts and an overall environment that is conducive to staff and client development.

The system records performance on selected indicators of quality in five (5) audit areas: 1) administrative, 2) clinical, 3) fiscal, 4) physical, and 5) programmatic indicators. These audit components, or areas for evaluation, may vary depending on the program, organizational needs, complexity, goals, or staff/client requests. The areas may be converted to specific measurable objectives. For example, under Programmatic Audit, Individualized Program Plan Development, the indicator citing independence and self-direction may include objectives to measure clients' progress in medication management, accessing community transportation, or developing leisure recreation skills. These audit indicators may be different from indicators for another program or agency. Audit indicators may change within the same program or agency over time. If the system is auditing program components that have little measurable direct impact on perceived quality, or is auditing measures of little value to the system's participants, the system as a whole is diminished and the value of its audit becomes questionable. Hence, the value of the system over time is directly affected by its capacity to accept and incorporate changes.

What steps does an organization take to implement a quality services management system? In developing a quality services management system, certain considerations drive its development. The program or agency needs 1) internalized, recognized communication processes to coordinate and facilitate system development and implementation. This step may make use of existing program administration, such as department directors, program coordinators, or quality services coordinators. Ideally, the existing organizational structure should be used to avoid duplicity, confusion, or crossing lines of communication. Once structured and formalized, the central quality services management committee will begin its most important work. The communication processes should include input from other subgroups whose interest in quality of services is critical to system development. These subgroups include but are not limited to parents associations, client councils, individual clients, or other informal or formal groups which may offer valuable guidance in developing system mission, philosophy, goals, or indicators. 2) An ongoing educational program for all staff. The development of a relevant and functional system, and hence, quality programs, is dependent on accurate assessment of staff educational needs. These needs should be assessed in an organized manner with opportunities for direct staff input. Concern for quality in client services begins with staff, all staff, no matter where they are assigned. Staff must know how their individual and collective efforts contribute to the organization, how important their responsibilities are to and for clients, what their jobs are, why they are expected to work in a prescribed manner. Program managers must ensure that staff are able to evaluate their actions based on their understanding of quality and how it is recognized in each person's work. This understanding may be developed via direct inservice training on selected quality services management topics or indirectly as a component of each inservice topic regularly offered which addresses administrative, clinical, fiscal, physical, or programmatic concerns. For example, in providing psychopharmacological services, the agency promotes quality in client rights when teaching staff about informed consent, prohibitions against chemical restraint, and proactive, positive interaction with clients to promote self-governance.

3) Basic ground rules which specify an audit schedule for reassessing indicators as often as needed or at least annually. Audit schedules may specify procedures for determining indicators, evaluation, needed corrective action, and follow-up review. Ground rules may provide for formal recognition of quality in action among staff and clients, encourage innovation, creativity, and provide an open forum for participants to suggest changes where needed.

4) again, that organizational mindset which values staff and recognizes that staff values guide attitudes and subsequently, behaviors.

Let's review six (6) important steps in establishing an internal monitoring system such as quality services management. These steps may occur simultaneously, as parallel processes. 1) Develop a mission statement, philosophy, and goals. Appoint a person to coordinate program development.

2) Define service areas for audit. 3) Operationalize the process. Make QSM a "tangible" entity in the organization. As the organization determines what indicators are important to its QSM program, some tracking methodology may be developed for long-term data collection and analysis. Let me emphasize that QSM must be more than a paper compliance to standards. It is an attitudinal intent to pursue the highest standards of personal best..to have each employee personify the mission, not simply be driven by the system, that distinguishes QSM from other quality assurance measures.

Nevertheless, human services tends to evaluate its progress as more valid if supported by data which exposes trends toward improvement. If we can see progress in measurable, quantifiable outcomes, we are more convinced of the success or worth of our efforts. Likewise, our ability to attest to a program's worth, to be accountable for fiscal and human resources, may rest on the data collected. Having noted such a need, early development of the system should include procedures for audit of selected areas with regular, standardized methods of data collection. 4) Develop reporting protocol on which indicators will be recorded. Protocols should be identical for all user departments and provide space for noting comments about the audited indicator. 5) Establish internal monitoring schedule. Conducting audits, documenting and reporting results, post conferences with administrative staff, corrective action plans, and follow-up audits should be coordinated in a manner which permits at least annual audit of selected indicators. 6) Design and implement a training program. A comprehensive, ongoing training program is of paramount importance if the originating enthusiasm is to be sustained and recharged over time. Direct interaction with each employee is the best method. Each person needs to feel that they are of direct and critical importance to the client and the "organization" needs to communicate regularly that employees are valued. The interplay of these factors is the heart of the quality services management concept. Within these parameters, training will be provided on a ongoing schedule for all employees, newly hired and seasoned veterans.

Implications for Administrators in the Coming Decade

The field of human services has evolved remarkably over the past thirty years. As may be expected, we are influenced by systemic changes in allied fields, by social, political, and economic issues in the macroenvironment. Anyone who has worked in services during this period has witnessed the emergence of numerous panaceas designed to alleviate problems. Likewise, we have seen such solutions evaporate or be replaced with "newer, better" panaceas as other issues emerge. There seems to be an absence of continuity when analyzing situations requiring intervention. It's as if we must have some new angle, some new methodology with its own unique acronym to be valid or worthy of consideration. But service providers should know by now that reinvented wheels are rare commodities. As Crosby (1979) related, "Just about nothing is new, and almost everything used to be worse".

Goode (1990) makes a valid point about our current "fascination", if you

will, with quality of life. Quality of life has a great many definitions and greater difficulty in assessment with any true reliability or validity. He cautions us to be wary of allowing quality issues to become rhetoric or maybe only something that people talk about once a year at conventions. Crosby (1979) contends that quality of life is, in fact, a cliche' because it is impossible to convey the identical perception between listener and speaker. Each assumes that the other has the same frame of reference.

So how do we galvanize a group of people with diverse interests and concerns...parents, clients, service providers, and advocates across diverse service settings? Quality services management is one solution to the administrative dilemma. QSM provides an impetus for management to act responsibly and responsively to direct program analysis and enhancement with the diverse interests of many subgroups in mind because these groups can participate in QSM development from the program's inception. Indeed, as a system, its utility and functionality are dependent, in large measure, on the commitment, understanding, and follow-through devoted to its early evolution in a given service setting.

We need to bear in mind a notion which is central to most discussion about quality. While presently available instruments may have varying empirical stringency, the improvements, unity arising from staff and clients' efforts, and additional research contributed to the body of professional knowledge lead us to a worthwhile conclusion. The pursuit of "quality" with its many definitions is meaningful because quality is a life concept we all value. The pursuit of quality requires continual accountability and programmatic activism and a willingness to enunciate the positive outcomes as freely and frequently as negative outcomes. At this time in the field of human services, the pursuit of quality may yet more clearly define those aspects of life and humanness most desired by all citizens.

Quality Services Management:
Suggested Classification System
for Performance Indicators

In absence of any external categorization which parallels classification of indicators, the subjective description of these guides represents an effort to apply "weighting" to quality efforts. The classification serves only to quickly and clearly denote those indicators judged to have maximum benefit or, conversely, to have the greatest potential adverse outcome. It may be considered that programs with a preponderant number of Class 1 observations will take immediate corrective action to prevent continuation of these citations in preference to indicators of less serious consequences. System suggests audit scheduling during the year where some indicators may infer annual or biannual analysis as Class 3 or Class 4 guides.

Class 1:

Indicators reference elements which deal with areas that have direct, serious impact to the physical or emotional health and safety of clients. Any actions reflecting negatively on any client's well-being are matter of primary concern. All staff are responsible to initiate direct immediate intervention, and corrective action to relieve client's concerns under Class 1 conditions.

Class 1 elements related to facility administrative, fiscal, and physical audits are judged to have an indirect but potential adverse outcome on client concerns. Actions related to these audit areas represent critical violations of fundamental facility policies, procedures, or practices and necessitate direct immediate intervention and corrective action to prevent continuation or reoccurrence.

Class 2:

Indicators reference elements which evaluate services promoting client's social, emotional, adaptive, vocational, development but do not reference serious and immediate jeopardy. These elements include but are not limited to outcome-oriented measurement of continuous active treatment, docmunetary compliance with certain client-related services, or other program services. Class 2 elements related to facility administrative, fiscal, and physical audits have an indirect outcome on client concerns. Elements related to these audit areas

will result in serious consequences to facility operations without corrective action plan to prevent continuation or reoccurence.

Class 3:

Indicators reference elements which document the provision of continuous active treatment in areas subject to direct observation. Actual performance of staff-client activities represent a higher priority than documentation of those activities, stressing outcome over process. Class 3 elements related to facility administrative, fiscal, or physical audits have moderate to minimal outcome on client concerns. Elements related to these audit areas will result in detrimental internal consequences or loss of productive work time to facility operations without corrective action plans to prevent continuation or reoccurrence.

Class 4:

Indicators reference elements which document standardized internal regulations, policies, procedures and practices specific to the monitoring agency. Class 4 elements are regarded as correctible at the first level of supervision, that is, not requiring written corrective action plan.

Suggested Readings

Albrecht, K. (1983). Organizational development: A total systems approach to positive change in any business organization. Englewood Cliffs, NJ: Prentice-Hall.

Andrew, K.R. (1980). The concept of corporate strategy. Homewood, IL: Richard D. Irwin, Inc.

Bennis, W. and Nanus, B. (1985). Leaders. New York, NY: Harper and Row, Inc.

Bersani, H. (1989). Assuring residential quality: issues, approaches, and instruments. Syracuse, NY: Syracuse University.

Bradley, V.J. and Bersani, H.A.. Quality assurance for individuals with developmental disabilities. Baltimore, MD: Paul H. Brooks, Company.

Cashen, J. (1988). Setting the stage for ideas of excellence. Paper presented at a conference of the National Association of Private Residential Resources (NAPRR), Fort Lauderdale, FL.

Crosby, P. (1979). Quality is free: The art of making quality certain. New York, NY: McGraw-Hill Company.

Ibid, (1984). Quality without tears. New York, NY: McGraw-Hill Company.

Dronsfield, J. (1989). Evolution of quality assurance, risk management, and utilization management in healthcare. Paper presented at MMI Company seminar, Boston, MA.

Drucker, P. (1980). Managing in turbulent times, New York, NY: Harper and Row.

Dufresne, D. (1990). "The role of service providers in quality assurance", Quality assurance for individuals with developmental disabilities, edited by Bradley, V. and Bersani, H. Baltimore, MD: Paul H. Brooks Company.

Enz, C. (1986). Power and shared values in the corporate culture. Ann Arbor, MI: University Microfilms, Incorporated.

Goode, D. (1990). "Measuring the quality of life of persons with disabilities: some issues and suggestions". News and notes. Washington, D.C., American Association on Mental Retardation.

Knoll, J. A. (1990). "Defining quality in residential services", Quality assurance for individuals with developmental disabilities. Baltimore, MD: Paul H. Brooks Company.

Peters, T. (1987). Thriving on chaos: a handbook for management revolution. New York, NY: Harper and Row, Incorporated.

Purcell, G. (1988). Quality assurance/utilization management, and risk management: deterrents to professional liability. Clinical Obstetrics and Gynecology, 31-1.

Rothschild, W. (1976). Putting it all together: a guide to strategic thinking. New York, NY: AMACOM.

Webber, J. and Peters, J. (1982). Strategic thinking: new frontiers for hospital management. New York, NY.

Wray, L. (1990). "The role of quality assurance in public agencies", Quality assurance for individuals with developmental disabilities edited by Bradley, V. and Bersani, H.. Baltimore, MD: Paul H. Brooks, Company.